burien wellness

You were born to be healthy.

Date: ____/____/_____

Pediatric Patient Information

Name: _____ Date of birth: ____/____/_____

Street address: _____ City: _____

State: _____ Zip code: _____ Email address: _____

1st Parent/Guardian's Name: _____ Relationship: _____

2nd Parent/Guardian's Name: _____ Relationship: _____

Parent 1 Phone: (_____)_____ Parent 2 Phone: (_____)_____

Emergency Contact Name / Phone: _____ / (_____)_____

Whom may we thank for referring you? _____

Insurance provider: _____ Prefix and ID#: _____

Health Information

What is the reason for your visit? ☐ Wellness ☐ Physical Complaint ☐ Accident ☐ Other

Prenatal History

1. Complications during pregnancy: ☐ No ☐ Yes: _____
2. Maternal substance use: ☐ Alcohol ☐Tobacco ☐ Other: _____
3. Maternal vaccinations or medication during pregnancy: ☐ No ☐ Yes _____
4. Illness or infection during pregnancy: ☐ No ☐ Yes _____
5. Ultrasounds or other testing: ☐ No ☐ Yes _____

Birth History

1. Place of birth: ☐ Home ☐ Birth Center ☐ Hospital
2. Birth Provider: ☐ Midwife ☐ OB-GYN ☐ Other
3. Type of Birth: ☐ Vaginal (vertex) ☐ Vaginal (breech) ☐ Cesarean
4. Interventions during labor: ☐ Pain Medication ☐ Pitocin ☐ Epidural ☐ Vacuum Extraction ☐ Forceps ☐ Twisting/Pulling ☐ Other: _____
5. Was labor induced? ☐ No ☐ Yes If yes, why? _____
6. APGAR score: _____ ☐ Unknown
7. Did the child experience any of the following? ☐ Misshapen skull ☐ Torticollis ☐ Colic

(see reverse)

Childhood History

1. Has your child been vaccinated? ☐ No ☐ Yes
    a. Reason: ☐ Informed Consent ☐ Pediatrician Recommended ☐ Didn't Know I Had A Choice
2. Did your child have any negative reaction to the vaccines? ☐ No ☐ Yes
    a. If yes, were they reported? ☐ No ☐ Yes
3. Does your child have food or seasonal allergies? ☐ No ☐ Yes _____
4. Has your child been on any medications, including antibiotics? ☐ No ☐ Yes
    a. If yes, how often and for what purpose? _____
5. Has your child ever been hospitalized? ☐ No ☐ Yes _____

Baby/Toddler (0-5 Years Old)

Have any of the following occurred?

Jaundice	Colic	Reflux
Anemia	Frequent diarrhea	Fall from a height <4 feet
Cyanosis	Frequent constipation	Fall from a height >4 feet
Seizures	Sleeping problems	Fall down stairs
Tonsillitis	Frequent fevers	Use of a soft structured carrier
Frequent ear infections	Frequent colds/viral infections	Car accident

Other: _____

Child/Teen (6-17 Years Old)

Have any of the following occurred?

Fall from a height <4 feet	Autism/Asperger's	Asthma
Fall from a height >4 feet	Leg/knee pain	Allergies
Sports accident	Arm/shoulder pain	Headaches/migraines
Car accident	Growing pains	Anxiety/depression
Stomach pain/indigestion	Learning difficulties	Scoliosis
Hyperactivity/ADHD	Bed-wetting	Severe menstrual cramps

Other: _____

1. Which of the above symptoms bothers your child the most? _____
2. Does it affect activity? ☐ Rarely ☐ Somewhat ☐ Always
3. Does your child participate in any athletics or other extra-curricular activities? ☐ No ☐ Yes
    a. If yes, which, and how often? _____
4. Rate your child's diet. ☐ Well-Balanced ☐ Average ☐ Below Average/High Processed
5. Child's sleep quality? ☐ Excellent ☐ Fair ☐ Poor
6. Average nightly sleep? ☐ >12 hours ☐ 9-12 hours ☐ 6-9 hours ☐ <6 hours

Is there anything else the doctor should know? _____

_____